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Sheila Foster

Yael Cannon

Maxwell Gregg Bloche

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Health Justice Is Racial Justice: A Legal Action Agenda For Health Disparities

Sheila Foster, Yael Cannon, Gregg Bloche

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The Brent family is still haunted by memories of the day they were evicted from their apartment, leaving all five homeless. Two years in shelters and motels followed before the family was able to secure housing assistance and find a home. Then came COVID-19. Their Washington, D.C. neighborhood was beset by soaring infection and mortality rates.

Mr. Brent lost his job, the kids were hungry, and the Brents could not make their rent. They feared being evicted and becoming homeless again. (“Brent” is a pseudonym used to preserve attorney-client confidentiality.)

Before COVID’s appearance, average life expectancy in the Brents’ Southeast D.C. ward, where **90-plus percent** of residents are African American, was **fifteen years shorter** than for residents of the city’s highest-income, predominantly white ward. A noxious brew of marginal economic possibility, unsafe housing, food insecurity, under-resourced schools, environmental hazards, and chronic stress in communities like the Brents’, where many Americans of color live, has led to profound racial inequities in health and lifespan.

The grotesquely disparate impact of the Coronavirus has drawn unprecedented national attention to this health injustice. The virus may not discriminate, but social structures do, creating shocking differences in vulnerability: **More than 20 percent** of DC’s reported COVID deaths have occurred in the Brents’ ward, where **only 11 percent of the city’s residents live**. Nationwide, the **picture is similar**.

Law And The Structure Of Health Inequity

This injustice is no accident. It stems in large measure from racist laws and policies—governance schemes that have entrenched racial segregation and stratification across a range of goods, services, and systems, including housing, environmental protection, transportation, access to healthy sources of food, and the availability of green and recreational spaces.

Conventional wisdom holds that COVID has hit African American neighborhoods disproportionately hard due to underlying comorbidities such as COPD, obesity, diabetes, high blood pressure, and cardiac disease. But these comorbidities are tied to underlying structural inequalities created and furthered by laws and policies that reflect and reinforce racial stratification.

For instance, higher COVID mortality rates occur in counties with high levels of fine particulate air pollution (PM 2.5, or particles less than 2.5 micrometers in size), according to a recent **study**. As **previous studies have documented**, race and exposure to PM 2.5 are strongly correlated; Black-White disparities are more pronounced than are disparities on the basis of income. COVID is, in the main, a respiratory disease. We know that chronic respiratory illnesses **present disproportionately in African American communities** and that asthma, in particular, has been linked to poor outdoor and indoor air quality, including the presence of mold and cockroaches in substandard housing.

Similarly, racial inequities in access to healthy food and availability of green amenities like parks and other recreational spaces correlate with (and likely contribute to) disparities in obesity. In addition to these inequities, [racism is itself a major stressor](#) and indeed an [ongoing public health crisis](#), experienced in settings ranging from employment to police interactions, and can contribute to heart disease, hypertension, and other illnesses made worse by emotional distress.

Much of the structural inequality that drives these disparities in health arises from the operation of law. Zoning and land use laws have concentrated polluting facilities in communities of color, which are more likely to be zoned mixed use industrial and residential. Through racial zoning, redlining, and housing discrimination practices, African Americans were historically excluded from single-family or single-family and commercial neighborhoods with better-quality housing, less pollution, and environmental amenities such as parks.

Even after those practices were legally outlawed, [racist lending practices persisted](#). They persist today, [locking neighborhoods into economic and racial segregation and disadvantage](#). For renters in many places, [eviction rates among African American households are multiple times those of whites](#), forcing African Americans into more substandard housing. Poor enforcement of building codes and warranties of habitability also put renters in substandard housing, at heightened risk for both eviction and owners' reluctance to remedy dangerous conditions. Better enforcement of these existing legal protections would be a start in addressing the vulnerability of low-income renters, [most of whom are African American, Latinx, and Native American](#).

Leveraging Existing Law

Existing law can and should be leveraged now to address the disparities in vulnerability that have put African Americans and other people of color at greater risk for COVID and other life-impairing and life-shortening health conditions. For example, students and attorneys at Georgetown Law's [Health Justice Alliance](#) negotiated a rent reduction for the Brent family and helped the family to secure food stamps and unemployment benefits for Mr. Brent. The family avoided eviction and the devastating [health impact of homelessness](#); the Brents, moreover, were no longer food insecure, another driver of poor health, [especially for children](#).

Earlier, similar advocacy proved so critical to the health of [pediatric patients at Boston Medical Center](#) that the hospital embedded legal aid lawyers, sparking the burgeoning [medical-legal partnership movement](#). Pediatricians found that many low-income patients with asthma kept getting sick, despite treatment, due to poor housing conditions,

including mold. By insisting on housing-code adherence, the lawyers reduced the incidence and severity of asthma attacks. Legal services attorneys around the country now [collaborate with hospitals, federally qualified health centers, and other health systems](#), employing law as a potent tool to advance health and well-being. Law, medical, and nursing students are learning to work as teams, through medical-legal partnerships like the [Georgetown University Health Justice Alliance](#), to address social determinants of health.

Incorporating advocacy of this sort into primary care for marginalized populations nationwide could go far to ameliorate conditions of life and racist policies that beget disease. Coverage for such advocacy should be included in Medicaid and other health insurance for low-income Americans. It could even [pay for itself](#), by preventing illness and thereby averting use of costly clinical services.

Seizing This Moment: An Agenda for Urgent Reform

It's past time to ensure the least advantaged among us have the power to safeguard their rights, under existing law, to conditions of life that don't endanger their health. No low-income American should face eviction and the threat of homelessness without having a lawyer to champion his or her rights. And all with low incomes should be afforded representation by counsel when litigation implicates other laws core to a person's health and well-being.

A [resolution](#) now pending in Congress would recognize a right to counsel without cost for low-income Americans in civil proceedings related to basic human needs, including health, sustenance, and shelter. The resolution invokes the U.S. Supreme Court's decision more than half a century ago, in *Gideon v. Wainwright*, recognizing the right to counsel in criminal proceedings. A right to counsel in civil cases has been [endorsed by the American Bar Association](#) and is garnering growing support amidst Depression levels of unemployment, a likely surge in [evictions as moratoria expire](#), and rising numbers of new coronavirus infections.

Beyond this, the transformed political climate that's resulted from COVID's shockingly disparate racial impact, the murder of George Floyd, and the ensuing mass protests opens the way for structural reforms that once seemed out of reach.

Laws and policies that have played critical roles in facilitating environmental racism and maintaining residential segregation can be re-engineered to de-concentrate disadvantage in communities of color. For example, [some cities have banned illness-causing land uses](#)

and barred industries that are harmful to the public's health and the environment from being sited in already heavily polluted communities.

Other cities have reformed their zoning laws to achieve racial equity by doing away with exclusionary rules that have shaped racial stratification. Minneapolis, for example, has eliminated single-family zoning to enable construction of more multi-family homes in those same areas. Eliminating single-family zoning will reduce systemic barriers to entry by African Americans into previously segregated neighborhoods.

New laws are also needed to take on the toxic stress caused by racism in employment, policing, and other contexts. The protests spurred by George Floyd's murder have highlighted the need for new rules and standards to reduce extreme racial disparities in arrests for low-level offenses—disparities that are a cause of so much stress and trauma for African Americans.

More broadly, America's awakening to the urgency of both health justice and racial justice can and should drive reforms that ensure decent incomes, equitable educational and career opportunity, quality housing and nutrition, and action to preserve the environment long-term. There's no small risk that we'll lose this moment—that half-measures and lip service will substitute for difference-making change. But our national shock over the unfairness COVID has revealed can energize America's next, great leap toward justice.

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Health Affairs

7500 Old Georgetown Road, Suite 600

Bethesda, Maryland 20814

T 301 656 7401

F 301 654 2845

customerservice@healthaffairs.org

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